DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01-005

2. STATE: Arizona

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.40; 42 CFR 483.12

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 0
b. FFY 2002 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-C

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-C

10. SUBJECT OF AMENDMENT:
Payments for Reserved Beds

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Lynn Dunton

13. TYPED NAME:
Lynn Dunton

14. TITLE:
Assistant Director

15. DATE SUBMITTED:
April 25, 2001

16. RETURN TO:
AHCCCS
Mail Drop 4200
801 East Jefferson
Phoenix, AZ 85034

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
May 7, 2001

18. DATE APPROVED:
7-13-01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
for Linda Minamoto

22. TITLE:
Associate Regional Administrator
Division of Medicaid

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ARIZONA

PAYMENTS FOR RESERVED BEDS

1. Payment for a reserved bed will not be made in an acute care facility.

2. Payment for a reserved bed may be made in a nursing facility, an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or a Residential Treatment Center licensed as a Level I behavioral health facility and accredited by an AHCCCS-approved accrediting body, subject to the following conditions:

   a. The purpose of the absence is to visit family or friends, to prepare the individual for discharge to community living or for an admission to an acute and/or psychiatric hospital;

   b. The member's plan of care provides for such an absence when therapeutic leave is utilized;

   c. The absence does not exceed nine therapeutic leave days and 12 bed hold days per contract year for adults age 21 and older, or a total of 21 days (therapeutic and/or bed hold) for persons under 21 years of age;

   d. Prior authorization is received from the designee for the Regional Behavioral Health Authority (RBHA) or Program Contractor.

3. Payment shall be denied for any absence that is:

   a. in excess of these limits;

   b. for purposes other than those listed; or

   c. not properly authorized.